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NEW CLIENT INFORMATION FORM: ADOLESCENT

This form to be completed by a parent or guardian of the adolescent client

BACKGROUND INFORMATION

Client's Name: _____ DOB: _____ Gender: _____

Client's Address: _____

Client's Home Phone: _____ Client's Cell Phone: _____

Parent 1 Name: _____ Cell Phone: _____

Parent 2 Name: _____ Cell Phone: _____

Child lives with: _____

If parents are divorced, describe custody arrangements: _____

_____

Emergency Contact Person (other than parent): _____

Emergency Contact Phone: _____

CLIENT EDUCATION INFORMATION

Current Grade: 7 8 9 10 11 12 Other: _____

Name of School: _____

Name of School Counselor: _____

Problems in School? _____

_____

CLIENT MEDICAL INFORMATION

Do you have health insurance? Yes No

If yes, insurance provider: Regence First Choice Health Other: _____

Are you planning to use insurance for your child's mental health counseling? Yes No

Primary Care Physician: _____ Phone: (____)_____

Is your child currently receiving medical treatment? Yes No

If Yes, Please Specify: _____

List any previous conditions, illnesses, or injuries that your child has been diagnosed with or treated for: _____

Current Medications: Dosage: Taking for:

_____

_____

_____

PARENT 1 INFORMATION

Name: _____ Age: _____ Gender: _____

Relationship to Child: _____

Employer: _____ Occupation: _____

Can you be contacted at work? Yes No Work Phone: _____

Are you currently receiving medical treatment? Yes No

Describe any health issues that require ongoing care: _____

_____

Previous counseling/therapy? Yes No

With whom and for how long? _____

PARENT 2 INFORMATION

Name: _____ Age: _____ Gender: _____

Relationship to Child: _____

Employer: _____ Occupation: _____

Can you be contacted at work? Yes No Work Phone: _____

Are you currently receiving medical treatment? Yes No

Describe any health issues that require ongoing care: _____

_____

Previous counseling/therapy? Yes No

With whom and for how long? _____

FAMILY INFORMATION

Has anyone in your family had problems with drug or alcohol addiction? Yes No

If so, who/when: _____

Has anyone in your family (including family friends) attempted or completed suicide? Yes No

If so, who/when: _____

Does your family regularly attend a place of worship? Yes No

If yes, where: _____

How important are spiritual matters to you/your family? Not at all Somewhat Very much

Would you like your spiritual/religious beliefs to be included in your child's counseling? Yes No

List any additional members of your household:

Name: Gender: Current Age: Relationship to Client:

_____

_____

_____

_____

PRESENTING ISSUES

Please tell me why you are seeking counseling for your child: _____

_____

_____

_____

How long have these concerns been causing distress? _____

Please check the boxes below if you've had concerns with any of the following in your child:

Aggressiveness	Past	Present	Loneliness	Past	Present
Alcohol Abuse	Past	Present	Loss of Control	Past	Present
Anger	Past	Present	Making Decisions	Past	Present
Anxiety	Past	Present	Memory	Past	Present
Apathy	Past	Present	Nervousness	Past	Present
Bad Dreams	Past	Present	Pain	Past	Present
Change in Appetite	Past	Present	Panic	Past	Present
Compulsivity	Past	Present	Physical Abuse	Past	Present
Depression	Past	Present	Racing Thoughts	Past	Present
Difficulty Breathing	Past	Present	Rapid Heart Rate	Past	Present
Digestive Upset	Past	Present	School Performance	Past	Present
Dizziness	Past	Present	Serious Illness	Past	Present
Drug Abuse	Past	Present	Sexual Abuse	Past	Present
Eating Problems	Past	Present	Sexualized Behaviors	Past	Present
Emotional Instability	Past	Present	Sleep Trouble	Past	Present
Fatigue	Past	Present	Social Anxiety	Past	Present
Fears	Past	Present	Stress	Past	Present
Finances	Past	Present	Trauma	Past	Present
Grief/Loss	Past	Present	Trouble Focusing	Past	Present
Guilt	Past	Present	Trouble Relaxing	Past	Present
Headaches	Past	Present	Unhappiness	Past	Present
Hearing Noises/Voices	Past	Present	Unwanted Thoughts	Past	Present
Hopelessness	Past	Present	Verbal Abuse	Past	Present
Impulsive Behavior	Past	Present	Worrying Excessively	Past	Present

Is there anything else you want to share about your child or your family? _____

_____

_____

Who referred you to me? _____

May I have your permission to thank this person for the referral? Yes No

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my child's personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____